COBRA Continuation of Coverage

Overview

The American Recovery and Reinvestment Act of 2009 (ARRA) provides Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) premium assistance for certain individuals whose qualifying event is the covered employee's involuntary termination of employment. Also, certain individuals, whose qualifying event is the covered employee's involuntary termination of employment, who initially declined to elect COBRA coverage, or elected it and subsequently discontinued it, may be afforded another opportunity to elect COBRA coverage.

ARRA applies to group health plans sponsored by private sector employers and state and local governmental employers that employ at least 20 employees. ARRA also applies to the Federal Employees Health Benefits Program. State "mini-COBRA" plans provided through health insurance issuers are also subject to the ARRA premium assistance provisions, but not the additional election period requirement (unless state insurance law or regulation adopts that requirement). For more information about ARRA, go to the "Downloads" section at the bottom of this page and select "Helpful Information about State Continuation Coverage and ARRA". Also, links to ARRA information that is posted on the Department of Labor's (DoL) and the Department of the Treasury's Websites are provided below under "Related Links Outside CMS". Model ARRA-related notices and forms will be posted on DoL's Website.

If after reviewing the ARRA-related material on the above cited Websites, you have additional ARRA-related questions, you may direct your questions to the appropriate entity as follows:

(1) with respect to continuation coverage provided by private sector employers that employ at least 20 employees, contact the US Department of Labor, Employee Benefits Security Administration, at 1-866-444-3272;

(2) regarding the applicability of ARRA to State mini-COBRA plans, contact your State's Department of Insurance, go to "Related Links Inside CMS" select the "Health Insurance Reform for Consumers" Web page, scroll to the "Downloads" section and select "DOI Contact Information - State Status Chart"; and

(3) ARRA-related questions with respect to other plans maybe directed to the Centers for Medicare & Medicaid Services (CMS) via email to NewCobraRights@cms.hhs.gov.

This section provides information about public sector COBRA continuation of coverage. The information in this section will be of interest to state and local government employers that maintain group health plan coverage for their employees, their plan administrators and plan enrollees.

The landmark COBRA health benefit provisions became law in 1986. The law amends the Employee Retirement Income Security Act, the Internal Revenue Code and the Public Health Service Act to provide continuation of employer-sponsored group health coverage that otherwise might be terminated. CMS has advisory jurisdiction for the COBRA law as it applies to state and local government (public sector) employers and their group health plans. (See Related Link Outside CMS at the bottom of this page.) Click on "Federal Jurisdiction" on the left navigation bar for information about contacting the federal agencies that administer private sector COBRA and the continuation of coverage provisions for federal employees.

The COBRA law generally applies to group health plans maintained by employers with 20 or more employees in the prior year. The law does not, however, apply to plans sponsored by the governments of the District of Columbia or any territory or possession of the United States, certain church-related organizations or the federal government. (The Federal Employees Health Benefit Program is subject to generally similar, although not parallel, temporary continuation of coverage provisions under the Federal Employees Health Benefits Amendments Act of 1988.)

Individuals who work for a state or local government employer, and their dependents, should be aware of their rights regarding COBRA. A good starting point is reading your summary plan description (SPD) booklet, if a state or local government employer distributes an SPD to its employees. Most of the specific rules on COBRA rights may be found there or with the person who manages your health benefits plan. Also, this Website provides detailed information about COBRA. Use the left navigation bar to access information related to a specific area of COBRA-related inquiry. Also, see "COBRA Helpful Tips" in the downloads section below. Additionally, the "More Information"

page contains a link to COBRA questions and answers. If you are unable to find the COBRA-related information you are looking for on this Website, you may e-mail us at phig@cms.hhs.gov, except for ARRA COBRA related inquiries which should be emailed to NewCobraRights@cms.hhs.gov.

Federal Jurisdiction

Public Sector COBRA: The Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services, has advisory jurisdiction with respect to the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) as it applies to state and local government employers and their group health plans.

The public sector COBRA law is set forth at 42 USC 300bb-1 through 300bb-8 (Title XXII of the Public Health Service Act), and is entitled "Requirements for Certain Group Health Plans for Certain State and Local Employees." (See Related Links Outside CMS at the bottom of the Overview page.) The public sector COBRA law (42 USC 300bb-7) provides for a private cause of action if an individual is denied a COBRA right under such a group health plan.

Private Sector COBRA: If your group health plan is sponsored by a private sector employer, you should contact the Employee Benefits Security Administration (EBSA), Department of Labor, or the Internal Revenue Service (IRS), Department of the Treasury. EBSA and IRS share jurisdiction with respect to COBRA as it applies to private sector employers and their group health plans. EBSA (telephone number 1-866-444-3272 (toll-free) or 202-219-8776) has lead authority with respect to reporting and disclosure provisions, which includes requirements that plans notify individuals of their right to elect COBRA continuation coverage; IRS (telephone number 202-622-6080) has lead authority with respect to coverage and tax sanction provisions. However, EBSA also can answer private sector COBRA coverage questions.

Continuation Coverage for Federal Employees: If your group health plan is a Federal Employees Health Benefit Plan (FEHBP), you should contact your agency's Human Resources Department for more information on temporary extensions of FEHBP benefits. The Office of Personnel Management, Office of Insurance Programs (telephone number 202-606-0745), has ultimate jurisdiction with respect to

FEHBP coverage.

Who Is Eligible - Qualifying Events

There are three elements to qualifying for the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) benefits. COBRA establishes specific criteria for plans, qualified beneficiaries, and qualifying events. These elements will determine the period of coverage.

Plans: Group health plans maintained by employers with 20 or more employees on more than 50% of their typical business days in the previous calendar year are subject to COBRA. Both full- and part-time employees are counted to determine whether a plan is subject to COBRA. Each part-time employee counts as a fraction of an employee, with the fraction equal to the number of hours that the part-time employee worked divided by the hours an employee must work to be considered full-time.

Qualified Beneficiaries: A qualified beneficiary generally is an individual covered by a group health plan on the day before a qualifying event. Depending upon the event, the following individuals may be qualified beneficiaries: a "covered employee" (a term that includes active employees, terminated employees and retirees); a covered employee's spouse and dependent children; any child born to or placed for adoption with a covered employee during the period of COBRA coverage; agents; self-employed individuals; independent contractors and their employees; directors; political appointees; and elected officials.

Qualifying Events: "Qualifying events" are certain events listed in the COBRA law that would cause an individual to lose health coverage. The type of qualifying event will determine who the qualified beneficiaries are and the amount of time that a plan must offer the health coverage to them under COBRA. (Click on "Standard Periods of Coverage," "Extended Periods of Coverage," and "Contracted Periods of Coverage" on the left navigation bar.) A plan, at its discretion, may provide longer periods of continuation coverage.

The qualifying events for covered employees are

- voluntary or involuntary termination of employment for any reason other than "gross misconduct."
- reduction in the number of hours of employment.

The qualifying events for spouses are

- voluntary or involuntary termination of the covered employee's employment for any reason other than "gross misconduct."
- reduction in the hours worked by the covered employee.
- covered employee's becoming entitled to Medicare.
- divorce or legal separation of the covered employee.
- death of the covered employee.

The qualifying events for dependent children are the same as for the spouse with one addition

- loss of "dependent child" status under the plan's rules.

Covered Benefits

Health care benefits provided under the terms of a group health plan that are available to Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) beneficiaries may include

- Inpatient and outpatient hospital care
- Physician care
- Surgery and other major medical benefits
- Prescription drugs
- Any other health care benefits, such as dental and vision care

Life insurance, however, is not covered under COBRA.

Group health plans must offer coverage to qualified beneficiaries that is identical to that available to similarly situated individuals who are not receiving COBRA coverage under the plan (generally, the same coverage that the qualified beneficiary had immediately before qualifying for continuation coverage). For example, a qualified beneficiary may have had medical, hospitalization, dental, vision and prescription benefits under a single or multiple plans maintained by the employer on the day preceding the qualifying event. That qualified beneficiary may elect to continue all benefits or choose to continue only certain benefits (if active employees are permitted to select specific benefits and decline other benefits under the plan or plans).

A change in the benefits under the plan for active employees will also apply to qualified beneficiaries. Qualified beneficiaries must be allowed to make the same choices given to non-COBRA enrollees under the plan, such as during periods of open enrollment by the plan. COBRA

beneficiaries remain subject to the rules of the plan and therefore are subject to catastrophic and other benefit limits to the same extent as non-COBRA plan enrollees.

Standard Periods of Coverage

The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) establishes required periods of coverage for continuation health benefits. COBRA beneficiaries generally are eligible for group coverage during a maximum period of 18 months for a qualifying event of employment termination or reduction of employment hours. Other qualifying events may entitle a spouse and dependent children to a total of 36 months of COBRA coverage.

COBRA Continuation Coverage		
Qualifying Event	**Beneficiary**	**Coverage**
Employee termination (other than by reason of gross misconduct) or reduced employment hours	Employee, Spouse, Dependent child	18 months
Employee enrolled in Medicare	Spouse / Dependent child	36 months
Divorce or legal separation	Spouse / Dependent child	36 months
Death of covered employee	Spouse / Dependent child	36 months
Loss of "Dependent child" status	Dependent child	36 months

A plan may provide longer periods of coverage than those required by COBRA. Also, events that occur during a period of COBRA coverage may extend or contract the coverage period. (Click on "Extended Periods of Coverage" and "Contracted Periods of Coverage" on the left navigation bar.)

Extended Periods of Coverage

29-Month Period (Disability Extension): Special rules for disabled individuals and certain family members may entitle them to

an 11-month extension of Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) continuation coverage (from 18 to 29 months). Specifically, if a qualified beneficiary is determined under Title II or XVI of the Social Security Act to have been disabled within the first 60 days of COBRA coverage, then that qualified beneficiary and all of the qualified beneficiaries in his or her family may be able to extend COBRA continuation coverage for up to an additional 11 months. (An individual who has been determined under Title II or Title XVI of the Social Security Act to have been disabled before the first day of COBRA continuation coverage, and who has not been determined to be no longer disabled at any time between the date of that disability determination and the first day of COBRA continuation coverage, is considered to be disabled within the first 60 days of COBRA continuation coverage.)

However, qualified beneficiaries may lose all rights to the additional 11 months of coverage if notice of the determination is not provided to the plan administrator within 60 days of the date of the determination (when the determination is issued during the initial 18-month period of COBRA coverage) and before the expiration of the 18-month period. The qualified beneficiary who is disabled or any qualified beneficiaries in his or her family may notify the plan administrator of the determination. (Click on "Notices Required of Qualified Beneficiaries" on the left navigation bar.)

18 to 36-Month Period (Special Rule): A special rule for dependents provides that if a covered employee becomes entitled to Medicare benefits (either Part A or Part B) before experiencing a qualifying event that is a termination of employment or a reduction of employment hours, the period of coverage for the employee's spouse and dependent children ends with the later of the 36-month period that begins on the date the covered employee became entitled to Medicare, or the 18- or 29-month period that begins on the date of the covered employee's termination of employment or reduction of employment hours. (Note that under this special rule, the employee's Medicare entitlement is not a qualifying event because it does not result in loss of coverage for the employee's dependents; thus, the 36-month coverage period would be part regular plan coverage and part continuation coverage.)

18 to 36-Month Period (Second Qualifying Event): A spouse and dependent children who experience a second qualifying event

may be entitled to a total of 36 months of COBRA coverage. Second qualifying events may include the death of the covered employee, divorce or legal separation from the covered employee, the covered employee becoming entitled to Medicare benefits (under Part A, Part B or both), or a dependent child ceasing to be eligible for coverage as a dependent under the group health plan. The following conditions must be met in order for a second event to extend a period of coverage:

(1) The initial qualifying event is the covered employee's termination, or reduction of hours, of employment, which calls for an 18-month period of continuation coverage;

(2) The second event that gives rise to a 36-month maximum coverage period occurs during the initial 18-month period of continuation coverage (or within the 29-month period of coverage if a disability extension applies);

(3) The second event would have caused a qualified beneficiary to lose coverage under the plan in the absence of the initial qualifying event;

(4) The individual was a qualified beneficiary in connection with the first qualifying event and is still a qualified beneficiary at the time of the second event; and

(5) The individual meets any applicable COBRA notice requirement in connection with a second event, such as notifying the plan administrator of a divorce or a child ceasing to be a dependent under the plan within 60 days after the event. (Click on "Notices Required of Qualified Beneficiaries" on the left navigation bar.)

If all conditions associated with a second qualifying event are met, the period of continuation coverage for the affected qualified beneficiary (or beneficiaries) is extended from 18 months (or 29 months) to 36 months.

Contracted Periods of Coverage

Continuation coverage generally begins on the date of the qualifying event (and may include a period of continuation coverage provided under the plan without regard to the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA)) and ends at the end of the

maximum period. A period of coverage may end earlier if

- an individual does not pay premiums on a timely basis.
- the employer ceases to maintain any group health plan.
- after the COBRA election, an individual obtains coverage with another employer group health plan that does not contain any exclusion or limitation with respect to any pre-existing medical condition an individual may have. (However, if other group health coverage is obtained on or before the date of the COBRA election, COBRA coverage may not be discontinued on account of the other coverage, even if the other coverage continues after the COBRA election. Click on "Coordination with Other Benefits" on the left navigation bar.)
- after the COBRA election, a beneficiary first becomes entitled to Medicare benefits. (However, if Medicare entitlement, either Part A or Part B, is effective on or before the date of the COBRA election, COBRA coverage may not be discontinued on account of Medicare entitlement, even if the individual enrolls in the other part of Medicare after the date of the election of COBRA coverage.

Notices Required of Employers or Plans

Initial Notice: A group health plan (or employer) must provide an initial notice describing the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) rights to each covered employee and spouse of the employee (if applicable) at the time coverage under the plan begins. The plan may send a single notice addressed to a covered employee and the covered employee's spouse at their joint address, provided the plan's latest information indicates that both reside at that address. Alternatively, a plan may send separate notices to an employee and the employee's spouse.

The plan must send a separate initial notice to a spouse under the following circumstances: an employee receives his or her initial notice at the workplace (in-hand delivery of the initial notice to an employee is permissible but does not constitute delivery to the spouse); the employer or plan has knowledge that the spouse resides at a different address than the employee; a spouse's coverage under the plan begins at a different time than the covered employee's coverage.

Other Notices: Other notice requirements are triggered for employers and plan administrators when a qualifying event occurs. Employers must notify plan administrators of a qualifying event within 30 days after an employee's death, termination, reduced hours of employment, or entitlement to Medicare (when an employee's Medicare entitlement results in loss of plan coverage for the employee's dependents). (An employee or other qualified beneficiary must notify the plan administrator of certain other events within 60 days of the
event, but the employer or plan administrator is responsible for informing them of that requirement. Click on "Notices Required of Qualified Beneficiaries" on the left navigation bar and view, in particular, the "Important Note.")

Plan administrators, upon receiving notice of a qualifying event, must provide an election notice to qualified beneficiaries of their right to elect COBRA coverage. Because qualified beneficiaries have independent election rights, plan administrators should either include a separate election notice for each qualified beneficiary in a single mailing that is addressed to both the employee and spouse, or, if a single notice is sent, it should clearly identify all qualified beneficiaries covered by the notice and explain each person's separate and independent right to elect COBRA coverage.

A plan administrator must always send separate election notices to qualified beneficiaries who do not reside at the same address if the different addresses are known to the plan administrator. A notice sent to the spouse is treated as a notification to all qualified dependent children residing with the spouse at the time the spouse's notification is sent by the plan administrator. Notices must be provided in person or by first class mail within 14 days after the plan administrator receives notice that a qualifying event has occurred.

Notices Required of Qualified Beneficiaries

An employee or qualified beneficiary must notify the plan administrator of a qualifying event within 60 days after divorce (or legal separation if that results in loss of plan coverage) or a child's ceasing to be covered as a dependent under the plan's rules. Also, a qualified beneficiary must notify the plan administrator within 60

days of those events when they occur during the initial 18 or 29-month period of coverage in order to qualify for an extension of the coverage period to 36 months.

If a second qualifying event is the death of the covered employee or the covered employee becoming entitled to Medicare benefits, a group health plan may require qualified beneficiaries to notify the plan administrator within 60 days of those events, as well. Ordinarily, the employer is responsible for notifying the plan administrator of an event that is the death of a covered employee or the covered employee becoming entitled to Medicare benefits. However, if the covered employee's employment has been terminated, the employer may not be in a position to be aware of those events. If the plan does not require qualified beneficiaries to notify the plan within 60 days of a second qualifying event that is the death of the covered employee or the covered employee becoming entitled to Medicare benefits, a qualified beneficiary should provide that notice by the later of the last day of the 18-month period or the date that is 60 days after the date of the second event.

Qualified beneficiaries who wish to take advantage of the 11-month disability extension generally must notify plan administrators of the disabled qualified beneficiary's disability determination under the Social Security Act on a date that is both within 60 days after the date of the disability determination and prior to the expiration of the initial 18-month period of COBRA coverage. However, if the date of the disability determination is before the date of the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) qualifying event, a qualified beneficiary can meet the 60-day requirement by notifying the plan administrator of the disability determination within an alternative 60-day period specified by the plan, such as within the 60-day COBRA election period.

The plan cannot require an individual who receives a disability determination under the Social Security Act before experiencing a COBRA qualifying event that is the covered employee's termination, or reduction of hours, of employment to notify the plan of the determination within 60 days of the determination because that requirement expressly applies to a "qualified beneficiary." An individual whose disability determination is issued before the COBRA qualifying event is not a "qualified beneficiary" at the time the

disability determination is issued.

If the plan does not specify an alternative 60-day period with respect to a disability determination issued before the qualifying event, the qualified beneficiary is required to notify the plan of the disability determination only within the initial 18-month period of continuation coverage. Qualified beneficiaries also must notify the plan administrator within 30 days after the date of any final determination that a qualified beneficiary is no longer disabled under Title II or Title XVI of the Social Security Act.

Important Note: With regard to the obligation of qualified beneficiaries to notify the plan administrator of certain events within a 60-day period, it is CMS's position that if a plan failed to properly inform a qualified beneficiary regarding that obligation, the plan, in determining whether an individual qualifies for COBRA coverage or an extension of COBRA coverage, must disregard the qualified beneficiary's failure to meet the 60-day notification requirement.

The law plainly places the burden of informing individuals of their COBRA rights on group health plans sponsored by state or local government employers. (Either the employer or plan administrator must provide an initial notice of COBRA rights when an individual commences coverage under the plan and again following a COBRA qualifying event.) A notice of COBRA "rights" must address all of the requirements for which an individual is responsible in order to elect and maintain COBRA continuation coverage for the maximum period. A plan cannot hold an individual responsible for COBRA-related requirements when the plan fails to meet its statutory obligation to inform an individual of those requirements.

Electing COBRA Coverage

Qualified beneficiaries must be given an election period of at least 60 days during which each qualified beneficiary may choose whether to elect Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) coverage. This period is measured from the later of the coverage loss date or the date the COBRA election notice is provided. COBRA coverage is retroactive if elected and paid for by the qualified beneficiary.

Each qualified beneficiary may independently elect COBRA coverage. For instance, if an employee retires and enrolls in an

employer-sponsored retiree plan that does not cover dependents, the retiree's spouse, and any dependent children, may elect COBRA (for a period of 18-months). A covered employee or the covered employee's spouse may elect COBRA coverage on behalf of all other qualified beneficiaries. A parent or legal guardian may elect on behalf of a minor child.

If a qualified beneficiary waives COBRA coverage during the election period, he or she may revoke the waiver of coverage before the end of the election period. Revocation of the waiver is an election of COBRA continuation coverage. However, in that case, the plan need only provide continuation coverage beginning on the date the waiver is revoked rather than from the coverage loss date.

Paying for Coverage

Group health coverage for COBRA participants is usually more expensive than health coverage for active employees, since usually the employer pays a part of the premium for active employees while COBRA participants generally pay the entire premium themselves. COBRA coverage may be less expensive, though, than individual health coverage.

Premiums for COBRA continuation coverage cannot exceed 102 percent of the cost to the plan for similarly situated individuals who have not experienced a COBRA qualifying event. The cost to the plan is both the portion paid by employees and any portion paid by the employer before the qualifying event. The COBRA premium can equal 100 percent of that combined amount plus a 2 percent administrative fee.

For example, if the cost of providing health benefits coverage for a similarly situated employee who has not experienced a COBRA qualifying event is $400 per month, $100 of which is paid by the employee and $300 of which is paid by the employer, the plan may charge an individual a COBRA premium of up to $408 per month (102 percent times $400). The employer is not responsible for any portion of the individual's COBRA premium, but may, if it wishes, pay a portion, or all, of the qualified beneficiary's premium.

For qualified beneficiaries receiving the 11-month disability-based extension of coverage (click on "Extended Periods of Coverage" on the left navigation bar for more information about the 11-month

extension), the premium for those additional months may be increased from 102 percent to 150 percent of the plan's total cost of coverage as long as the disabled qualified beneficiary participates in the additional coverage. Non-disabled qualified beneficiaries may participate in the additional coverage even if the disabled qualified beneficiary does not. In that event, the plan cannot charge the non-disabled qualified beneficiaries that participate in the 11-month extension more than the 102 percent rate for the entire period of coverage, including the 19th through the 29th month of coverage.

COBRA premiums may be increased if the costs to the plan increase for similarly situated non-COBRA beneficiaries, but, for COBRA purposes, such premiums generally must be fixed in advance of each 12-month premium cycle. The plan must allow you to pay premiums on a monthly basis, if you wish, but may give you the option to make payments at other intervals (for example, weekly or quarterly).

You (or someone on your behalf) must make the initial premium payment within 45 days after the date of your COBRA election; the payment generally must cover the period from the coverage loss date through the month in which the initial payment is made. However, if you only need COBRA coverage for a short period of time, such as one or two months, you can pay only for those months from the coverage loss date.

After you make the initial premium payment, subsequent premiums (usually paid on a monthly basis) are considered to be timely if made by the date due or within a grace period of 30 days after the date due (or longer period as applies to or under the plan). Payment is considered to be made on the date it is sent to the plan.

If you do not make premium payments by the first day of the period of coverage, the plan has the option to cancel coverage until payment is received and then reinstate the coverage retroactively to the beginning of the period of coverage if payment is made within the grace period. Alternatively, the plan can hold any claims received during the grace period and then process them if the premium payment is made within the grace period, or deny them and terminate coverage effective the first day of the period of coverage for which payment is not made within the grace period.

If the amount of the payment you make to the plan is in error but is

not significantly less than the amount due, the plan may accept the payment as satisfying the plan's requirement for the amount that must be paid. Alternatively, the plan is required to notify you of the deficiency and grant a reasonable period (for this purpose, 30 days is considered reasonable) to pay the difference. The plan is not obligated to send monthly premium notices or payment coupons.

COBRA beneficiaries remain subject to the rules of the plan and therefore must satisfy all costs related to co-payments and deductibles.

Coordination with Other Benefits

The Family and Medical Leave Act (FMLA), effective August 5, 1993, requires an employer to maintain coverage under any "group health plan" for an employee on FMLA leave under the same conditions coverage would have been provided if the employee had continued working. Coverage provided under the FMLA is not Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) coverage and FMLA leave is not a qualifying event under COBRA. A COBRA qualifying event may occur, however, when an employer's obligation to maintain health benefits under FMLA ceases, such as when an employee notifies an employer of his or her intent not to return to work.

Further information on FMLA is available from the nearest office of the Wage and Hour Division, listed in most telephone directories under U.S. Government, Department of Labor, Employment Standards Administration.

An individual who is covered under another group health plan or who is entitled to Medicare may elect and retain COBRA continuation coverage for the maximum period of coverage if the other group health plan coverage or Medicare entitlement begins on or before the date on which the individual elects COBRA continuation coverage.

Also, if other group health plan coverage begins after the date on which the individual elects COBRA continuation coverage, the individual is entitled to retain COBRA coverage for the maximum period if under the other group health plan coverage the individual is subject to any exclusion or limitation with respect to any pre-existing condition.

Other Coverage Considerations

In deciding whether to elect Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) continuation coverage, you should consider all your health care options. For instance, one option that may be available is "special enrollment" in a group health plan sponsored by a spouse's employer, if enrollment is requested within 30 days of loss of your health coverage. (If you decide to elect COBRA coverage, special enrollment also is available in a spouse's plan after COBRA continuation coverage is exhausted). The special enrollment right is provided by the Health Insurance Portability and Accountability Act (HIPAA) and permits an individual who loses group health plan or health insurance coverage to enroll in a spouse's plan without having to wait for an open enrollment period. If a group health plan provided by a spouse's employer is insured by a health insurance carrier, contact your state's department of insurance for more information about special enrollment rights. Also, regarding special enrollment in a plan maintained by a state or local government employer, you can contact CMS at phig@cms.hhs.gov.

If the group health plan provided by a spouse's employer is a self-funded, private sector (not a state or local government) plan, contact the Employee Benefits Security Administration, Department of Labor (telephone # 1-866-444-3272 (toll free) or 202-219-8776).

Also, individuals in a family may be eligible for health insurance coverage through various state programs. For more information about state programs, contact your state's department of insurance.

If you elect COBRA continuation coverage, options that may have been available to you before electing COBRA coverage may still be available after COBRA coverage is exhausted. Additionally, you and your family may qualify for individual health coverage as "HIPAA-eligible individuals" when COBRA coverage is exhausted. (COBRA coverage is exhausted when it ends for any reason other than either failure of the individual to pay premiums on a timely basis or for cause, such as making a fraudulent claim.)

HIPAA eligible individuals are eligible to purchase individual health coverage on a guaranteed available basis with no exclusion period for preexisting medical conditions. Certain criteria must be met.

For more information about obtaining individual health coverage as a "HIPAA-eligible individual," contact your state's department of insurance, preferably before your COBRA coverage ends. Also, you can contact CMS at 1-877-267-2323 extension 61565.

Although COBRA specifies certain periods of time that continued health coverage must be offered to qualified beneficiaries, COBRA does not prohibit plans from providing continuation coverage beyond the periods required by COBRA. Also, some plans allow participants and beneficiaries to convert group health coverage to an individual policy. If this option is available from the plan, the COBRA law gives you the right to exercise that option when you reach the end of your COBRA continuation coverage. The plan must offer a qualified beneficiary the option of enrollment in a conversion health plan within 180 days before COBRA coverage ends. The premium for a conversion policy may be more expensive than the COBRA premium, and the conversion policy may provide a lower level of coverage. The conversion option, however, is not available if the qualified beneficiary ends COBRA coverage before reaching the end of the maximum period of coverage.

Important Note: One of the conditions that must be met to obtain individual health coverage as a HIPAA-eligible individual is that the individual's most recent period of coverage must be employer-sponsored group health plan coverage. COBRA coverage meets that requirement; a COBRA conversion policy does not. Federal law does not give an individual who takes a COBRA conversion policy a right to switch from the conversion policy to other individual health coverage on a guaranteed available basis.

More Information

CMS has prepared numerous questions and answers to assist qualified beneficiaries, state and local government employers and their group health plan administrators in understanding their rights and responsibilities with respect to public sector Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) continuation of coverage. CMS answers questions pertaining to the following sub-areas of COBRA-related inquiry: Applicability; COBRA Notices; Premiums; COBRA Coverage; Core and Non-Core Coverage; Coverage of Dependents; Multiple Qualifying Events; Other Group Health Plan Coverage and COBRA; Medicare and COBRA;

Enforcement. (See below for related link inside CMS.)

If an answer is based on a particular statutory provision, a citation for that provision is provided. (The public sector COBRA law is set forth in title XXII of the Public Health Service Act; 42 U.S.C. 300bb-1 through 300bb-8. Click on "Overview" on the left navigation bar and see related link outside CMS at the bottom of that page.)

Sometimes an answer is based on an Internal Revenue Service (IRS) regulation, which applies to private sector COBRA situations. While IRS COBRA regulations do not have force and effect with respect to public sector COBRA situations, and CMS has no authority to interpret IRS regulations, we rely on those regulations for guidance to the extent that there is no basis for differentiating between private and public sector COBRA. Accordingly, any reference to IRS regulations, which are set forth at 26 CFR §§ 54.4980B-1 through 54.4980B-10, is provided solely for informational purposes.

Please note that any given COBRA-related Q & A will not necessarily remain on the website on a permanent basis. The website is programmed to automatically delete a Q & A that does not receive at least 50 "hits" in a 6-month period. If you cannot find an answer to your specific question, you may e-mail us at phig@cms.hhs.gov.